MiR NEUROLOGY & SPINE CENTER

SARIM MIR, MD

PATIENT INFORMATION

PATIENTS NAME (LAST, FIRST, MIDDLE)				SOCIAL SECURITY #
HOME ADDRESS	APT #	CITY	STATE	ZIP CODE
HOME PHONE NUMBER	WORK NUMBER	CELL PHONE NUMBER		
☐ MALE ☐ FEMALE	DATE OF BIRTH:	EMAIL ADDRESS		
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOW ☐ SEPERATED		ARE YOU A STUDENT? ☐ YES ☐ NO		
PRIMARY CARE PHYSICIAN	PHONE #	REFERRING PHYSICIAN	PHONE #	
EMERGENCY CONTACT	RELATIONSHIP	PHONE #		

EMPLOYMENT INFORMATION

EMPLOYERS NAME				EMPLOYERS PHONE NUMBER
EMPLOYERS ADDRESS	CITY	STATE	ZIP CODE	
PATIENTS EMPLOYMENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ UNEMPLOYED ☐ RETIRED				OCCUPATION

INSURANCE

PRIMARY INSURANCE NAME AND ADDRESS		
POLICY #	GROUP #	EFFECTIVE DATE
POLICY HOLDER NAME	RELATIONSHIP TO PATIENT	POLICY HOLDERS DATE OF BIRTH
SECONDARY INSURANCE NAME AND ADDRESS		
POLICY #	GROUP #	EFFECTIVE DATE
POLICY HOLDER NAME	RELATIONSHIP TO PATIENT	POLICY HOLDERS DATE OF BIRTH
Is this work related or result of MVA? ☐ YES ☐ NO	**DATE OF INJURY**	**CLAIM #**
WORKERS COMP or MVA INSURANCE NAME		
ADDRESS	PHONE NUMBER	
ADJUSTERS NAME	ADJUSTERS PHONE #	

ADDITIONAL INFORMATION
RACE: ☐ American Indian ☐ Asian ☐ Black/African American ☐ White ☐ Other_______________ ☐ Prefer not to answer
ETHNICITY: ☐ Hispanic ☐ Not-Hispanic ☐ Prefer not to answer
LANGUAGE PREFERRED: ☐ English ☐ Spanish ☐ Other_______________ ☐ Prefer not to answer

Do you give our office permission to discuss your medical information with family members?

Name: ____ Relationship:__________________________ Phone:____________________

Name: ____ Relationship:__________________________ Phone:____________________

"I authorize Mir Neurology and Spine Center to apply the benefits on my behalf for the services rendered by Dr. Mir and staff. I request payment from my insurance or responsible party be made to Mir Neurology and Spine Center. I certify that all information I have provided is correct to the best of my knowledge. I authorize the release of any medical information for this claim or any related claim. I permit a copy of this authorization be used in place of the original. I may revoke this authorization at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay the medical services provided to me. I understand that payment is due when the statement is rendered. I have read and have received a copy of Mir Neurology and Spine Center's Notice of Privacy Practices."

Patient/Guardian Signature: ____ **Date:** ________________